

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185229		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/18/2012	
NAME OF PROVIDER OR SUPPLIER BARREN COUNTY HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD ST. GLASGOW, KY 42141			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated/partial extended survey (KY #19447) was conducted on 12/13/12 through 12/18/12. KY #19447 was substantiated with deficiencies cited. Immediate Jeopardy and Substandard Quality of Care was identified on 12/17/12 and determined to exist on 11/22/12 at 42 CFR 483.13 Resident Behavior and Facility Practices, F 223 and F226, at a scope and severity of a "J".</p> <p>On 11/22/12, between 12:00 Noon and 1:00 PM, Certified Nursing Assistant (CNA) #2 witnessed CNA #1 cross Resident #1's arms across his/her chest and push him/her in the wheelchair into the door; the door slammed; and the resident sustained a bruise to the forearm. Additionally, CNA #1 was witnessed to remove clothing from the resident's drawer and throw some of the clothing in the resident's face, stating "this will give you something to do". Resident #1 was witnessed to be upset and crying. CNA #2 left Resident #1's room and reported what she witnessed to Licensed Practical Nurse (LPN) #1. However, LPN #1 did not remove CNA #1 from direct resident care. CNA #1 was allowed to work, providing care to other residents, until the end of her shift at 3:00 PM. On 11/23/12, CNA #2 reported what she witnessed the day before to Registered Nurse (RN) #1, and RN #1 contacted the Administrator and initiated an investigation of the allegation. The completed investigation revealed there was possible mental and physical abuse by CNA #1 towards Resident #1 and CNA #1 was terminated.</p> <p>Immediate Jeopardy and Substandard Quality of Care was determined to exist on 11/22/12</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 through 12/03/12. The facility implemented corrective action prior to the State Survey Agency's investigation on 12/13/12, thus it was determined Past Jeopardy. The Immediate Jeopardy was determined to be removed on 12/04/12.	F 000			
F 223	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of personnel time records and review of the facility's policy and procedure and investigation it was determined the facility failed to have an effective system to ensure each resident was free from verbal and physical abuse for one resident (#1) in the selected sample of three residents. On 11/22/12, between 12:00 Noon and 1:00 PM, Certified Nursing Assistant (CNA) #2 witnessed CNA #1 cross Resident #1's arms across his/her chest and push him/her in the wheelchair into the door; the door slammed; and the resident sustained a bruise to the forearm. Additionally, CNA #1 was witnessed to remove clothing from the resident's drawer and throw some of the clothing in the resident's face, stating "this will	F 223	Past noncompliance: no plan of correction required.		

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F 223	<p>Continued From page 2</p> <p>give you something to do". Resident #1 was witnessed to be upset and crying. CNA #2 left Resident #1's room and reported what she witnessed to Licensed Practical Nurse (LPN) #1. However, LPN #1 did not remove CNA #1 from direct resident care. CNA #1 was allowed to work, providing care to other residents, until the end of her shift at 3:00 PM. On 11/23/12, CNA #2 reported what she witnessed the day before to Registered Nurse (RN) #1, and RN #1 contacted the Administrator and initiated an investigation of the allegation. The completed investigation revealed there was possible mental and physical abuse by CNA #1 towards Resident #1 and CNA #1 was terminated.</p> <p>The failure to ensure residents were free from verbal and physical abuse has caused, or is likely to cause, serious injury, harm, impairment, or death to Resident #1 and other residents in the facility. Immediate Jeopardy and Substandard Quality of Care was determined to exist on 11/22/12 through 12/03/12. The facility implemented corrective action prior to the State Survey Agency's investigation on 12/13/12, thus it was determined Past Jeopardy. The Immediate Jeopardy was determined to be removed on 12/04/12.</p> <p>The findings include:</p> <p>Review of the "Resident Abuse, Neglect, and Exploitation" policy/procedure, undated, revealed any incident of abuse or suspected abuse must be reported immediately to the available charge staff person (usually the charge nurse responsible for the resident's care on their tour of duty). The report was not limited to formal or</p>	F 223			

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F 223	<p>Continued From page 3</p> <p>written grievances but may include a verbalized complaint. The individual suspected of causing abuse was to be removed from the the facility and be put on administrative leave until the investigation was completed and an administrative decision was made by the administrator. The Director of Nursing (DON) and Administrator were to be notified immediately by the charge person who initially received the report.</p> <p>A review of the facility's investigation, dated 11/29/12, revealed an allegation of abuse was reported on 11/22/12 . On 11/22/12 at approximately 1:00 PM, an incident occurred between CNA #1 and Resident #1. Resident #1 scratched CNA #2 while assisting the resident in his/her room. CNA #1 grabbed Resident #1's hands, crossed them across his/her chest and pushed his/her wheelchair against the door, causing the door to slam shut and the resident sustained a bruise to the forearm. The facility determined there was possible mental and physical abuse and CNA #1 was terminated 11/29/12.</p> <p>Interview with CNA #2, on 12/13/12 at 2:36 PM, revealed she witnessed an incident between CNA #1 and Resident #1 on 11/22/12 between 12:00 Noon and 1:00 PM. She revealed she was in "shock" because she had never observed CNA #1 act that way before. She reported Resident #1 was trying to go down the brown hall when she intercepted the resident and escorted him/her back to his/her room on the white hall. CNA #1 was working on the hall and she assisted her to get the resident back to his/her room. Resident #1 was upset at the time and the resident dug</p>	F 223			

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F 223	<p>Continued From page 4</p> <p>his/her nails into CNA #2's arm. Once they were in the room, CNA #1 crossed Resident #1's arms across his/her chest and pushed the resident who was in his/her wheelchair into the door; the door slammed; and, the resident sustained a bruise to the forearm. Resident #1 was upset and crying and had a scared look on his/her face. CNA #1 grabbed clothes from the resident's drawer, tossed them on the bed and then picked them up and threw them at Resident #1's face stating "this will give you something to do". CNA #2 revealed she stood there and did not do anything. The CNAs left the room and walked up the hall to the nursing desk. CNA #2 reported the incident to LPN #1. The nurse verbalized she would have to write the situation up and she voiced she would wait until the next day to report the situation to Registered Nurse (RN) #1. She stated LPN #1 did not look into the allegation of abuse.</p> <p>A phone interview with CNA #1, the alleged perpetrator on 12/14/12 at 11:18 AM, revealed she denied shoving the resident into the door causing it to slam on his/her arm and throwing clothes in Resident #1's face. She was in the room with CNA #2. Another CNA was in the adjoining bathroom assisting a resident and did not see anything but stuck her head out the door to ask about the noise. CNA #1 explained Resident #1 had rolled back and hit the door because he/she was upset. They exited Resident #1's room because she was unable to calm the resident down and went to the nursing desk. She stated there was a nurse at the desk but she couldn't recall who and CNA #2 did not say anything to the nurse. She revealed she did not report anything to the nurse about the resident being upset and throwing clothes. She continued</p>	F 223			

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F 223	<p>Continued From page 5</p> <p>to work until the end of her shift at 3:00 PM. No staff came to her and asked her to leave related to an allegation of abuse.</p> <p>A review of a time report for CNA #1, for 11/22/12, revealed CNA #1 worked from 6:00 AM until 3:00 PM. She had a break at 9:15, lunch from 10:30 AM until 11:00 AM and a break at 1:15 PM.</p> <p>An interview with LPN #1, on 12/14/12 at 9:25 AM, revealed she was the nurse working in the facility on 11/22/12. After lunch, CNA #2 approached her and reported an allegation. She was informed that CNA #1 had pushed the resident in his/her wheelchair into the door and threw clothes in his/her face. She explained to CNA #2 they should report the incident to the nurse over on the white hall and CNA #2 asked her not to say anything to that nurse because CNA #1 and that nurse were friends. She did not say anything to the other nurse and CNA #1 was allowed to work until the end of her shift at 3:00 PM. She revealed she did not check on Resident #1 and did not talk with CNA #1 and remove her from care. She reported CNA #2 was left with the decision of what to do with the allegation. She exited the room and returned to her assigned duties. She revealed she had never dealt with abuse previously and was not aware of the facility's abuse policy requiring the removal of an "alleged perpetrator" from resident care areas even though she had received the policy and procedure upon hire and signed it.</p> <p>An interview with the DON, on 12/14/12 at 4:16 PM, revealed she was not in the facility on 11/22/12; however, she received a call from RN</p>	F 223			

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F 223	<p>Continued From page 6</p> <p>#1 on Friday (11/23/12) related to CNA #2 reporting an allegation of abuse that took place the day before. CNA #2 alleged CNA #1 crossed the resident's arms across the resident's chest and pushed him/her into the door. She then picked up some clothing and threw them in his/her face. She questioned RN #1, if CNA #1 was in the building and she was informed she was not on duty. RN #1 was advised to notify the Administrator and Assistant Director of Nursing (ADON); take statements from the staff; complete an assessment on Resident #1; and, the resident's physician and family about the incident.</p> <p>An interview with the Administrator, on 12/13/12 at 1:18 PM, revealed he was not in the facility on 11/22/12. He received a telephone call from RN #1 who stated she had received an abuse allegation that occurred the day before. He inquired about the "alleged perpetrator" and was informed she was not in the building. He advised RN #1 to notify CNA #1 she was on administrative leave pending the results of the investigation. He expected the staff to report the incident immediately (as soon as it happened) to the nurse and the nurse was expected to remove the perpetrator and call the DON and him. He stated they had a failure of the nurse receiving the complaint to follow the policy/procedure in place. The completed investigation revealed there was possible mental and physical abuse towards Resident #1. He revealed it was unclear because it was one staff's word against the other but determined they should separate CNA #1 from the facility. On 11/29/12, CNA #1 was informed she was terminated.</p> <p>A record review revealed Resident #1 was</p>	F 223			

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F 223	<p>Continued From page 7</p> <p>admitted to the facility on 12/24/07 with diagnoses to include Depressive Disorder, Insomnia, Abdominal Aortic Aneurysm, and Neoplasm of Bone. A review of the quarterly Minimum Data Set (MDS) Assessment, dated 11/05/12, revealed the facility assessed the resident as severely cognitively impaired.</p> <p>**The facility implemented the following actions to correct the deficiency:</p> <p>*On 11/23/12, Registered Nurse (RN) #1 initiated an investigation of the allegation of mistreatment of Resident #1. She notified the DON and Administrator of the allegation. Following notification, the Administrator arrived to the facility and coordinated the investigation. Interviews were conducted and CNA #1 was informed of being off on administrative leave pending an investigation.</p> <p>*The family was notified of the allegation of abuse by RN #1 on 11/23/12.</p> <p>*The MD of the affected resident was notified of the allegation by RN #1 on 11/23/12.</p> <p>*Self report incident to OIG/DCBS was completed by the Administrator on 11/23/12.</p> <p>*RN #1 completed a skin assessment of Resident #1 on 11/23/12 with bruising noted to the resident's left arm. Assigned licensed staff conducted skin assessments of all residents within the facility starting 11/22/12 and ending on 11/29/12. The staff did not identify any unexplained injuries to the residents.</p>	F 223			

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F 223	<p>Continued From page 8</p> <p>*All staff received education on the abuse/neglect policy/procedure prior to starting their next scheduled shift by RN #1 and the Staff Development Coordinator (SDC). Training was started on 11/23/12 and completed on 12/03/12. One LPN was on medical leave and will receive the education prior to returning to work.</p> <p>*The Abuse Coordinator on 11/27/12 interviewed residents living on the white hall about the care they had received from staff. The interviewable residents were asked specifically if CNA #1 had ever mistreated them and all reported "no one in the facility had mistreated them".</p> <p>*The Administrator initiated Continuous Quality Improvement on "Abuse Investigation and Reporting" on 12/12/12 and they would be asking the staff on each shift to verbalize the abuse policy and what they are expected to do.</p> <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>Record review for sampled residents and the other residents residing in the facility revealed the residents had their skin assessments completed from 11/22/12 through 11/29/12. The facility staff did not identify any injuries of unknown origin. Observation, on 12/13/12, 12/14/12, and 12/17/12 of the resident's interaction with staff, revealed no resident appeared afraid of the staff while care was being provided. Interviews, on 12/13/12, with interviewable residents, revealed the staff treated them well. The residents denied being mistreated by the facility staff.</p> <p>Record review validated the completion of</p>	F 223			

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F 223	<p>Continued From page 9</p> <p>training of all staff related to the abuse/neglect policy/procedure, on 11/23/12 and completed on 12/03/12.</p> <p>Interview with CNA #2, on 12/13/12 at 2:36 PM, CNA #3, on 12/14/12 at 2:15 PM, CMA #1, on 12/14/12 at 2:40 PM, LPN #1, on 12/14/12 at 9:25 AM, LPN #2, on 12/14/12 at 10:05 AM and RN #2, on 12/14/12 at 2:50 PM revealed they were knowledgeable and able to verbalize understanding of the abuse/neglect policy. Each staff person was able to verbalize what their responsibilities were if they observed or over heard something that was abusive or neglectful. Interview with CNA #2, CNA #3, and CMA #1 revealed they were to report abuse/neglect to the charge nurse as soon as it was witnessed. If the nurse did not respond, they are to tell another nurse in the facility. Interview with LPN #1, LPN #2, and RN #2 revealed upon receiving a report of abuse, they were to remove the person abusing the resident and protect the resident, notify the DON/ADON and Administrator of the allegation, and start an investigation.</p> <p>An interview with Social Services Director, on 12/14/12 at 3:16 PM, revealed she instructed the staff about abuse in orientation. She often worked with the Administrator and DON during an investigation of abuse. She informed the staff they were to report abuse as soon as it happens to the nurse. The nurse was expected to remove the abuser from the facility, ensure the resident was safe, and report the allegation to the Administrator and DON.</p> <p>An interview with the DON, on 12/17/12 at 9:00 AM, revealed staff was educated on 11/23/12</p>	F 223			

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F 223	Continued From page 10 regarding the abuse policy, going over specifically what each level of staff was expected to do. The re-training was very thorough. She stated they had interviewed staff and asked them to explain what to do if a patient was abused. Per interview, they had not identified any problems and the staff have responded appropriately. An interview with the Administrator, on 12/17/12 at 3:05 PM, revealed after the incident, the staff were immediately inserviced on our abuse policy. There was a CQI tool started related to talking to the staff randomly about what the current abuse policy. The ADON and Staff Development Coordinator completed the questioning of the staff. We did not identify any staff who were not able to recite what to do in case of abuse. Per interview, the Medical Director was informed of the incident when the facility became aware.	F 223			
F 226	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedures and investigation it was determined the facility failed to have an effective system to ensure implementation of written policies and procedures	F 226	Past noncompliance: no plan of correction required.		

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F 226	<p>Continued From page 11</p> <p>to protect one resident (#1), in the selected sample of three residents, from abuse. The facility failed to ensure protection of residents after an allegation of abuse, by allowing the alleged perpetrator to continue to provide direct care to residents. On 11/22/12, between 12:00 Noon and 1:00 PM, Certified Nursing Assistant (CNA) #2 witnessed CNA #1 cross Resident #1's arms across his/her chest and push him/her in the wheelchair into the door; the door slammed; and the resident sustained a bruise to the forearm. Additionally, CNA #1 was witnessed to remove clothing from the resident's drawer and throw some of the clothing in the resident's face, stating "this will give you something to do". Resident #1 was witnessed to be upset and crying. CNA #2 left Resident #1's room and reported what she witnessed to Licensed Practical Nurse (LPN) #1. However, LPN #1 did not remove CNA #1 from direct resident care. CNA #1 was allowed to work, providing care to other residents, until the end of her shift at 3:00 PM. On 11/23/12, CNA #2 reported what she witnessed the day before to Registered Nurse (RN) #1, and RN #1 contacted the Administrator and initiated an investigation of the allegation. The completed investigation revealed there was possible mental and physical abuse by CNA #1 towards Resident #1 and CNA #1 was terminated. (Refer to F223)</p> <p>The failure to ensure the protection of residents after an allegation of abuse has caused, or is likely to cause, serious injury, harm, impairment, or death to Resident #1 and other residents in the facility. Immediate Jeopardy and Substandard Quality of Care was determined to exist on 11/22/12 through 12/03/12. The facility</p>	F 226			

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F 226	<p>Continued From page 12</p> <p>implemented corrective action prior to the State Survey Agency's investigation on 12/13/12, thus it was determined Past Jeopardy. The Immediate Jeopardy was determined to be removed on 12/04/12.</p> <p>The findings include:</p> <p>Review of the "Resident Abuse, Neglect, and Exploitation" policy/procedure, undated, revealed any incident of abuse or suspected abuse must be reported immediately to the available charge staff person (usually the charge nurse responsible for the resident's care on their tour of duty). The report was not limited to formal or written grievances but may include a verbalized complaint. The individual suspected of causing abuse was to be removed from the the facility and be put on administrative leave until the investigation was completed and an administrative decision was made by the administrator. The Director of Nursing (DON) and Administrator were to be notified immediately by the charge person who initially received the report.</p> <p>A review of the facility's investigation, dated 11/29/12, revealed an allegation of abuse was reported on 11/22/12 . On 11/22/12 at approximately 1:00 PM, an incident occurred between CNA #1 and Resident #1. Resident #1 scratched CNA #2 while assisting the resident in his/her room. CNA #1 grabbed Resident #1's hands, crossed them across his/her chest and pushed his/her wheelchair against the door, causing the door to slam shut and the resident sustained a bruise to the forearm. The facility determined there was possible mental and</p>	F 226			

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F 226	Continued From page 13 physical abuse and CNA #1 was terminated 11/29/12. Interview with LPN #1, on 12/14/12 at 9:25 AM and 12/17/12 at 3:24 PM , revealed she was in charge of the brown, gold and orange hall of the facility on 11/22/12. CNA #2 reported to her an allegation of abuse after lunch. An interview with LPN #1, on 12/14/12 at 9:25 AM, revealed she was the nurse working in the facility on 11/22/12. After lunch, CNA #2 approached her and reported an allegation that CNA #1 had pushed the resident in his/her wheelchair into the door and threw clothes in his/her face. She talked with CNA #2 about reporting the incident to the other nurse in charge of the hall where Resident #1 lived, but she did not want to. LPN #1 reported she left the decision up to CNA #2 about what to do then she returned to work on her halls. She reported she did not let the other nurse know nor did she check Resident #1 to ensure he/she had not been injured. CNA #1 continued to provide direct care until the end of her shift at 3:00 PM. She did not remember CNA #2 saying anything else about the incident; however, she was upset and verbalized she "hated to see residents mistreated". She had not dealt with abuse/neglect in the past and she sent a text message to the DON. LPN #1 reported she informed the DON of the incident and what was being said. The DON informed her specifically what to do if another incident happened. She reviewed the policy on abuse/neglect when hired and took a test over it. LPN #1 would not acknowledge if she knew to remove the person alleged abusing a resident but verbalized she "now knew it a whole lot better".	F 226			

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F 226	<p>Continued From page 14</p> <p>Interview with Registered Nurse (RN) #1, on 12/13/12 at 3:01 PM, revealed she was made aware of the abuse allegation on 11/23/12, by CNA #2 and she notified the DON and Administrator of the allegation. The Administrator questioned if CNA #1 was on duty and he was informed she was not. He then gave instructions to call CNA #1 and inform her she was on administrative leave pending an investigation. The Administrator came in and started the investigation.</p> <p>An interview with the DON, on 12/14/12 at 4:16 PM, revealed she was not in the facility on 11/22/12; however, she received a call from RN #1 on Friday morning about the incident. Additionally, LPN #1 sent a text message to her regarding the what was reported to her by CNA #2 on Saturday. She revealed LPN #1 was informed specifically what the facility policy/procedure was on abuse and the employee accused (CNA #1) needed to be removed from direct care as this allegation was serious. She stated LPN #1 did not handle it immediately after she was made aware. LPN #1 told the aide to inform her charge nurse instead of addressing the issue with the "alleged perpetrator" by sending her home and starting an investigation per the policy.</p> <p>An interview with the Administrator, on 12//12 at 1:00 PM, revealed he was not at the facility on 11/22/12. He was telephoned by RN #1 and made aware an abuse allegation had been received. He inquired about the "alleged perpetrator" and was informed she was not in the building. He expected the nurse to remove CNA #1 from care immediately (as soon as it</p>	F 226			

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F 226	<p>Continued From page 15</p> <p>happened). During his investigation, he was made aware CNA #2 informed LPN #1 of the abuse, but she did not follow the policy related to the protection of residents. The facility's completed investigation revealed there was possible mental and physical abuse and CNA #1 was terminated 11/29/12.</p> <p>**The facility implemented the following actions to correct the deficiency:</p> <p>*On 11/23/12, Registered Nurse (RN) #1 initiated an investigation of the allegation of mistreatment of Resident #1. She notified the DON and Administrator of the allegation. Following notification, the Administrator arrived to the facility and coordinated the investigation. Interviews were conducted and CNA #1 was informed of being off on administrative leave pending an investigation.</p> <p>*The family was notified of the allegation of abuse by RN #1 on 11/23/12.</p> <p>*The MD of the affected resident was notified of the allegation by RN #1 on 11/23/12.</p> <p>*Self report incident to OIG/DCBS was completed by the Administrator on 11/23/12.</p> <p>*RN #1 completed a skin assessment of Resident #1 on 11/23/12 with bruising noted to the resident's left arm. Assigned licensed staff conducted skin assessments of all residents within the facility starting 11/22/12 and ending on 11/29/12. The staff did not identify any unexplained injuries to the residents.</p>	F 226			

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F 226	<p>Continued From page 16</p> <p>*All staff received education on the abuse/neglect policy/procedure prior to starting their next scheduled shift by RN #1 and the Staff Development Coordinator (SDC). Training was started on 11/23/12 and completed on 12/03/12. One LPN was on medical leave and will receive the education prior to returning to work.</p> <p>*The Abuse Coordinator on 11/27/12 interviewed residents living on the white hall about the care they had received from staff. The interviewable residents were asked specifically if CNA #1 had ever mistreated them and all reported "no one in the facility had mistreated them".</p> <p>*The Administrator initiated Continuous Quality Improvement on "Abuse Investigation and Reporting" on 12/12/12 and they would be asking the staff on each shift to verbalize the abuse policy and what they are expected to do.</p> <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>Record review for sampled residents and the other residents residing in the facility revealed the residents had their skin assessments completed from 11/22/12 through 11/29/12. The facility staff did not identify any injuries of unknown origin. Observation, on 12/13/12, 12/14/12, and 12/17/12 of the resident's interaction with staff, revealed no resident appeared afraid of the staff while care was being provided. Interviews, on 12/13/12, with interviewable residents, revealed the staff treated them well. The residents denied being mistreated by the facility staff.</p>	F 226			

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F 226	<p>Continued From page 17</p> <p>Record review validated the completion of training of all staff related to the abuse/neglect policy/procedure, on 11/23/12 and completed on 12/03/12.</p> <p>Interview with CNA #2, on 12/13/12 at 2:36 PM, CNA #3, on 12/14/12 at 2:15 PM, CMA #1, on 12/14/12 at 2:40 PM, LPN #1, on 12/14/12 at 9:25 AM, LPN #2, on 12/14/12 at 10:05 AM and RN #2, on 12/14/12 at 2:50 PM revealed they were knowledgeable and able to verbalize understanding of the abuse/neglect policy. Each staff person was able to verbalize what their responsibilities were if they observed or over heard something that was abusive or neglectful. Interview with CNA #2, CNA #3, and CMA #1 revealed they were to report abuse/neglect to the charge nurse as soon as it was witnessed. If the nurse did not respond, they are to tell another nurse in the facility. Interview with LPN #1, LPN #2, and RN #2 revealed upon receiving a report of abuse, they were to remove the person abusing the resident and protect the resident, notify the DON/ADON and Administrator of the allegation, and start an investigation.</p> <p>An interview with Social Services Director, on 12/14/12 at 3:16 PM, revealed she instructed the staff about abuse in orientation. She often worked with the Administrator and DON during an investigation of abuse. She informed the staff they were to report abuse as soon as it happens to the nurse. The nurse was expected to remove the abuser from the facility, ensure the resident was safe, and report the allegation to the Administrator and DON.</p> <p>An interview with the DON, on 12/17/12 at 9:00</p>	F 226			

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F 226	<p>Continued From page 18</p> <p>AM, revealed staff was educated on 11/23/12 regarding the abuse policy, going over specifically what each level of staff was expected to do. The re-training was very thorough. She stated they had interviewed staff and asked them to explain what to do if a patient was abused. Per interview, they had not identified any problems and the staff have responded appropriately.</p> <p>An interview with the Administrator, on 12/17/12 at 3:05 PM, revealed after the incident, the staff were immediately inserviced on our abuse policy. There was a CQI tool started related to talking to the staff randomly about what the current abuse policy. The ADON and Staff Development Coordinator completed the questioning of the staff. We did not identify any staff who were not able to recite what to do in case of abuse. Per interview, the Medical Director was informed of the incident when the facility became aware.</p>	F 226			